STATE OF MAINE
DEPARTMENT OF PREOFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE: DETERMINATION OF	**)**
AGGREGATE MEASURABLE	**)**
COST SAVINGS FOR THE SECOND	**)**
ASSESSMENT YEAR	**)**

Docket No. INS-06-900 June 23, 2006

BRIEF OF THE MAINE ASSOCIATION OF HEALTH PLANS

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NOW COMES the Maine Association of Health Plans ("MEAHP")[1] as an intervenor in this hearing regarding the determination of "aggregate measurable cost savings" (AMCS") for the second assessment year pursuant to the Dirigo Health Act, P.L. 2003 ch. 469, as amended by P.L. 2005, ch. 400 (the "Act"). The Act prescribes that the Board of Directors (the "Board") of the Dirigo Health Agency ("DHA") determine "annually not later than April 1st the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." 24-A M.R.S.A. §6912(1)(A). Although the Board failed to meet its April 1st deadline, the Board did hold an adjudicatory hearing on May 8 and 10, 2006, orally announced its decision following public deliberations on May 12, 2006, and filed its written decision with the Superintendent on June 9, 2006 (the "Decision").[2] Also on June 9, the Board filed the complete record in this case (the "Record").

The Board found AMCS for the second assessment year to be allocated among the following categories of savings:

a. hospitals voluntarily limiting cost increases to 4.5% as measured by expenses per Case Mix Adjusted Discharge ("CMAD") -- $14.2 million
b. avoidance or reduction of bad debt and charity care ("BD/CC") -- $2.7 million
c. the MaineCare Adults Expansion program ("MCAE") -- $3.9 million
d. the Woodwork Effect whereby people "came out of the woodwork" to enroll in MaineCare ("WW") -- $57,000
e. reduced spending on hospital and non-hospital infrastructure as a result of the $400,000 threshold for review in the Certificate of Need program and limits on the Capital Investment Fund program ("CON/CIF") -- $ 5.5 million

[1] MEAHP is an incorporated trade association of health plans; MEAHP's members are Aetna Health, Inc., Anthem Blue Cross/Blue Shield of Maine, CIGNA Health Care of Maine, and Harvard Pilgrim HealthCare.

[2] MEAHP submitted a Hearing Brief dated March 24, 2006, and a Supplemental Hearing Brief dated May 5, 2006, to the Board; those filings are attached hereto as Exhibits 1 and 2, respectively, and the arguments made in those filings are fully incorporated herein by reference just as if they were included in the text of this brief.

f. the time value of money stemming from accelerated payments to providers known as Prospective Interim Payments ("PIP") -- $7 million
g. future increased Medicaid payments to physicians ("FPP") -- $8.2 million.

These individual categories of savings fall into one of four so-called "savings initiatives" recognized by the Board:

a. Hospital Savings Initiatives (CMAD) -- $14.2 million
b. Uninsured Savings Initiatives (BD/CC, MCAE, and WW) -- $ 6,657,000
c. Certificate of Need and Capital Investment Fund Initiatives (CON/CIF) -- $5.5 million
d. Health Care Provider Fee Initiatives (PIP and FPP) -- $15.2 million

In sum, the Board concluded that AMCS for the second assessment year totaled $41,757,000.[3]

The Board's determination of AMCS for the second assessment year is now subject to review by the Superintendent, who is charged with determining whether and to what extent the Board's determination of AMCS is reasonably supported by the evidence in the record. 24-A M.R.S.A. §6913(1). The Superintendent's review of the Board's determination of AMCS follows two tracks. First, the Superintendent must determine whether and to what extent there is reasonable support in the record for the Board's decision to include all four savings initiatives (*i.e.*, Hospital Savings Initiatives, Uninsured Savings Initiatives, Certificate of Need and Capital Investment Fund Initiatives, and Health Care Provider Fee Initiatives) in its computation of AMCS for the second assessment year. Second, the Superintendent must determine whether and to what extent there is reasonable support in the record for the Board's calculation of the various amounts of putative savings ascribed to the various initiatives. And upon thorough review of the record in this case, the Superintendent should conclude (1) that only Uninsured Initiatives may be included in AMCS, and (2) that the Board's determination of $41,757,000 in AMCS for the

[3] The Board's written decision actually claimed $42,270,000 in AMCS, but counsel for the Board has recognized that the proper figure is $41,757,000.

second assessment year is not reasonably supported by the record evidence, and should be reduced for the reasons stated below below.

Before undertaking its review of the evidentiary record in this case, however, the Superintendent should take note of the significant procedural problems which arose in the course of the proceeding before the Board and which amount to fundamental due process violations. As a result of these due process violations, the Board's Decision is entirely unreasonable and so should be rejected by the Superintendent.

I. The Board's Decision is fundamentally unreasonably because it was made in spite of serious due process violations.

According to the Board's Notice of Pending Proceeding and Hearing dated January 27, 2006, the adjudicatory hearing before the Board was originally scheduled to begin on March 15, 2006; it was subsequently rescheduled to March 27, 2005. On March 7, 2006, however, DHA moved to continue the Board's hearing "to a date after August 1, 2006," and the Board determined that it would not rule on DHA's motion to continue until March 27, the very day the hearing was to commence; on March 21, the Board notified the parties that the adjudicatory hearing would commence on March 28 if DHA's pending motion to continue was not granted. Meanwhile, the Hearing Officer ruled that all interim deadlines remained in effect.

On the evening of March 20, after being specifically ordered to do so by the Hearing Officer and just 48 hours before MEAHP's pre-filed testimony was due, DHA, through its consultant Mercer Government Human Services Consulting ("Mercer"), filed an outline of its proposed methodology for its determination of AMCS for the second assessment year (the "March 20 Methodology"). The March 20 Methodology did not include any actual calculations or supporting documentation, but instead described the proposed methodology in only vague and

general terms, subject to varying interpretation. Most tellingly, the March 20 Methodology contained the following enormous caveat:

> The methodologies for cost savings that are presented here have been developed in the absence of much of the necessary data. As a result, the final methodologies may require some adjustments when the final data is utilized.

R-1407. (enphasis added). MEAHP continued to comply with the extant deadlines regardless of the impending continuance.

By Order dated March 27, 2006, the Board granted DHA's Motion to Continue. However, on appeal, the Superior Court ruled that the continuance was improper and by Order dated April 14, 2006, directed the Board to hold a hearing and determine AMCS for the second assessment year no later than May 12, 2006. By e-mail dated April 20, 2006, the Hearing Officer notified all parties that the hearing would take place on May 8 beginning at 9:00 a.m. At this point, DHA still had yet to provide any supplement to the preliminary and incomplete March 20 Methodology. After a conference call of all parties on April 27, 2006, the Hearing Officer issued an Order which required that DHA supplement its witness testimony by 5:00 p.m. on May 1 and that Mercer:

> supplement its [March 20 Methodology] report to the Dirigo Health Agency by 5:00 p.m. on May 2, 2006 and the Agency shall have it available for the parties in order to provide for a meaningful opportunity for review by the parties. This information shall include Mercer's calculation of the AMCS and all documents considered, reviewed, or relied upon for the report.

R-1033. (Emphasis added).

By e-mail of 5:23 p.m. on May 2, DHA provided a copy of Mercer's updated report entitled "Supplemental Report to the Dirigo Health Agency -- Dirigo Health Savings Offset Payment: Year 2 -- Methodology Update and Preliminary Calculations" (the "Supplemental

Report"). This report contained a caveat similar to the March 20 Methodology: "The calculations included within this report are incomplete and are not intended to represent the final savings for Year 2." R-1438. Approximately one half hour later, DHA again provided some, but again not all, of the documents considered, reviewed, or relied upon by Mercer in developing the Supplemental Report. As of May 8, 2006, the date of the first day of hearing, DHA had not yet provide all of the documentation considered, reviewed, or relied upon by Mercer in developing the Supplemental Report.[4] R-5021-24. Finally, after 8 p.m. on May 8, DHA produced what they purported to be a full set of all of the documents considered, reviewed, or relied upon by Mercer. By then the hearing before the Board was half over, with the remainder to commence 36 hours later on the morning of May 10. R-5021-24. Most astonishingly, DHA's expert witness Leonard Brauner then testified that on April 24 DHA gave him a complete set of the documents that DHA expressly failed to give to MEAHP until 8 p.m. on May 8. R-5108. This revelation begs two simple questions: (1) Why did DHA refuse to provide MEAHP with a complete set of documents in a timely fashion?, and (2) What should be done about it?

The answer to the first question lies in the murky waters of intent and would require examination of DHA officials, but the answer to the second question is crystal clear. Because DHA failed to produce all of the documentation supporting its determination of AMCS until half-way through the hearing before the Board, MEAHP's opportunity to participate fully and equally in the hearing was severely compromised. Therefore, MEAHP asks that the Superintendent find that the Board's determination of AMCS for the second assessment year is

[4] MEAHP will refrain from providing a summary of the struggle to obtain information from DHA and Mercer. Suffice it to say, the position taken by DHA and Mercer in response to freedom of access requests by MEAHP and Anthem was incredible in light of the great public interest in this matter.

fundamentally unreasonable insofar as the record evidence suggests that the procedure before the Board was fundamentally unfair.[5]

Moreover, in response to the due process violation recited above, MEAHP filed a motion on May 7, 2006, to exclude the testimony of DHA witnesses Steven Schramm and Leonard Brauner as well as pertinent portions of Mercer's Supplemental Report on the grounds that MEAHP and the Chamber, Anthem, and the Trust were prejudiced in their preparation for the hearing by DHA's failure to produce documents. R-1211. At the hearing on May 8 and again on May 10, MEAHP, the Chamber, Anthem, and the Trust also objected to the admission of Brauner's testimony and Schramm Exhibit # 4 (numerous Medicare cost reports). R-5021-24. During the hearing on May 8, the Board recognized that DHA had produced some but not all of the Medicare cost reports used by Mercer in its determination of AMCS for the second assessment year. R-5023. Rather than grant MEAHP's motion, however, the Hearing Officer ordered that DHA produce the missing reports by the end of that day. R-5023. The Board also ordered that Schramm's testimony on CMAD be suspended for the day and that he be made available to testify on CMAD about 36 hours later, at the commencement of the hearing on May 10. R-5023. The Board took the position that giving MEAHP and the other parties 36 hours to review this voluminous material would cure DHA's repeated failure to produce the requested material, and on May 10 the Hearing Officer announced that MEAHP's Motion to Exclude had been denied and that the reasons for the denial would be contained in the Board's written decision. R-5023, 5111. Subsequently, the Board admitted into evidence the testimony of

[5] The position taken by DHA and CAHC, that the untimely and incomplete document production is the result of necessary cost report data being unavailable, is not reasonable. In fact, DHA created and adopted a methodology for Year 1 that captured so many time-frames, both into the future and the past, that they left nothing to capture for Year 2 except savings even further into the future, *i.e.*. considering CON in a time period for which CON determinations had not yet been made as of the date of the Board's decision, and CMAD in a time period for which cost reports would not be available until several months after the Board's statutory April 1 deadline for making a determination of AMCS. Thus, the documentation problem is DHA's own making, and is a direct result of the aggressive nature of the Year 1 savings methodology.

Schramm and Brauner, the Medicare cost reports that DHA had previously failed to produce, and the CMAD portion of Mercer's Supplemental Report.

The Board's Decision offers no rationale for denying MEAHP's motion, and it is not the Superintendent's responsibility to create one. Therefore, there is no reasonable support in the record for the Board's denial of MEAHP's Motion to Exclude, and the Superintendent should not consider this evidence.

Even if the Superintendent is not inclined to dismiss the Board's Decision entirely, at the very least these serious due process violations indicate that the Superintendent should not give any deference to the Board's Decision.

II. The record does not reasonably support the Board's determination that AMCS includes categories other than Uninsured Initatives.

The Board concluded that putative savings related to seven separate categories – CMAD, CON/CIF, BD/CC, MCAE, WW, PIP, and FPP – in four different initiatives should be included in AMCS for the second assessment year. Contrary to the Board's decision, however, and regardless of the dollar amounts attributed by the Board to each category, the record does not contain reasonable support for the inclusion of anything other than Uninsured Initiatives within AMCS.

A. The Board's stated justifications for including initiatives other than Uninsured Initiatives in AMCS for the second assessment year is not reasonably supported by the record evidence.

The Board's flawed justifications for including putative savings related to initiatives other than Uninsured Initiatives – *i.e.*, Hospital Savings Initiatives, Certificate of Need and Capital Investment Fund Initiatives, and Health Care Provider Fee Initiatives – within AMCS is as follows:

1. Hospital Savings Initiatives (*i.e.*, CMAD)

On page 13 of the Decision, the Board provided the general basis for its conclusion that CMAD should be included as part of AMCS for the second assessment year: "the Board was persuaded that savings from CMAD for the second assessment year were influenced by the [Act]." R-5293. More specifically, the Board noted only that DHA "demonstrated through cross-examination of Steven Michaud, President of the Maine Hospital Association, that voluntary savings from CMAD for SFY 2005 were considered part of government initiated health care reform." R-5293. Besides a general reference to Mr. Michaud's testimony, the Board did not cite any other record evidence in support of its conclusion that CMAD should be included as part of AMCS for the second assessment year. Because the Board misapprehends Mr. Michaud's testimony – he did not say or even suggest "that voluntary savings from CMAD for SFY 2005 were considered part of government initiated health care reform" – and because there is no other record evidence to support the inclusion of CMAD within AMCS for the second assessment year, the Superintendent should conclude that CMAD (a/k/a "Hospital Savings Initiatives") should not be included as part of AMCS for the second assessment year.

2. Certificate of Need and Capital Investment Fund Initiatives (*i.e.*, CON/CIF)

On page 17 of the Decision, the Board provided the general basis for its conclusion that CON/CIF should be included as part of AMCS for the second assessment year: "The Board determined that the limits imposed on capital expenditures as a result of the [Act] were a critical part of the State's effort to contain the growth of health care expenditures and that the issue of hospital expansion was an important consideration in development of the State Health Plan." R-5297. More specifically, the Board only "noted the absence of any evidence contradicting the assumptions utilized by Mercer [*i.e.*, the assumption that putative savings attributable to CON/CIF were the result of the Act], including the absence of any testimony from Steven

Michaud of the MHA or any of the affected hospitals contradicting those assumptions." R-5297. Because the Board misapprehends both the burden of proof borne by DHA (at the very least, DHA was obligated to offer affirmative evidence in the record to prove that putative savings related to CON/CIF were justified as part of AMCS rather than positing an unsubstantiated hypothesis and then putting the burden on the intervenors to disprove it) and the nature of the testimony from Cathy Cobb (she presented no evidence linking hospitals' decisions to limit capital expenditures with any provisions of the Act), and because there is no other record evidence to support the inclusion of CON/CIF within AMCS for the second assessment year, the Superintendent should conclude that CON/CIF (a/k/a "Certificate of Need and Capital Investment Fund Initiatives") should not be included as part of AMCS for the second assessment year.

3. Health Care Provider Fee Initiatives (*i.e.*. PIP and FPP)

On page 19 of the Decision, the Board provided the basis for its conclusion that PIP and FPP should be included as part of AMCS for the second assessment year: "The Board determined that the fee initiatives were linked to the [Act]." R-5299. More specifically, the Board only "noted the [pre-filed] testimony of Commissioner Wyke with regard to the reasons for the hospital settlement, the increased PIP payments and the increase in physician fees; the testimony of Mr. Schramm that Mercer had taken into account the hospital tax; and the Hospital Study Commission's recommendations leading to the fee initiatives." R-5298. Additionally, the Board noted that the Act "established the Hospital Study Commission … [which] recommended that the legislature take action with regard to past shortfalls in Medicaid reimbursement rates and the increased cost to physicians of providing access to MaineCare patients." R-5298. Because the Board misapprehends the record evidence regarding the fundamental nature of the payments

constituting PIP and FPP as well as the Hospital Study Commission vis-à-vis the Dirigo Act, the Superintendent should conclude that PIP and FPP (a/k/a "Health Care Provider Fee Initiatives") should not be included as part of AMCS for the second assessment year.

B. There is no reasonable support in the record for the Board's conclusion that the terms of the Act permit categories other than Uninsured Initiatives to be included in AMCS for the second assessment year.

Any reasonable methodology for determining AMCS according to the terms of the Act must be limited to the categories of putative savings that are identified in the Act. The Act specifically prescribes that the determination of AMCS shall include

> any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

24-A M.R.S.A. §6913(1). No other provision of the Act directs or even suggests that DHA may include any other sources of putative savings in a calculation of AMCS. Thus, the Act delineates only two possible categories of AMCS: (1) "the reduction or avoidance of bad debt and charity care costs to health care providers … as a result of the operation of Dirigo Health"; and (2) "any increased enrollment due to an expansion of MaineCare eligibility." 24-A M.R.S.A. §6913(1). "Dirigo Health" itself is defined in the Act as "an independent executive agency to arrange for the provision of comprehensive, affordable health care coverage…." 24-A M.R.S.A. § 6902. Because the Act defines "Dirigo Health" as a State-owned insurance carrier, its "operation" necessarily consists of offering subsidized insurance products. The language of the Act bears this out by referring to "any reduction or avoidance of bad debt and charity care costs" (*i.e.*, BD/CC) as the only measure of savings attributable to "the operation of Dirigo Health." Accordingly, only savings identified in the Act – Uninsured Initiatives – may be included in any determination of AMCS.

Despite the express limitations of the Act, however, and with only the justifications described above, the Board included within its determination of AMCS putative savings related to several categories wholly unrelated to the definition of savings in the Act – *i.e.*, Hospital Savings Initiatives, Certificate of Need and Capital Investment Fund Initiatives, and Health Care Provider Fee Initiatives. Because DHA's key witness Schramm admitted repeatedly that there is no basis in the language of the Act or its legislative history for including these categories of putative savings within AMCS, the Superintendent should find that the record does not reasonably support the Board's conclusion that categories of savings other than Uninsured Initiatives should be included in AMCS. R-5048, 5049, 5094, and 5131.

In order to reach the conclusion that AMCS was not limited by the express terms of the Act to only Uninsured Initiatives, the Board adopted an interpretation of the Act that is essentially limitless:

> [T]he law, as enacted, in the Board's view, does not limit AMCS to [Uninsured Initiatives]. Section 6913 only states that savings are to include any reduction or avoidance of bad debt and charity care and increased MaineCare enrollment; it neither limits savings to these initiatives nor expressly states what other initiatives may be considered by the Board in making a determination of AMCS.

R-5289. Thus, the Board's view is that the inventory of potential categories of savings to be included in AMCS is constrained not by law but only by DHA's imagination.

In taking this tack, the Board leapt from the frying pan into the fire. By recognizing categories of savings other than Uninsured Initiatives on the grounds that the Act does not "expressly state[] what other initiatives may be considered by the Board in making its determination of AMCS," the Board endorsed a fundamentally unconstitutional premise – if the terms of the Act do not adequately describe what is to be included as AMCS, then it is unconstitutionally vague. See, e.g., City of Chicago v. Morales, 527 U.S. 41, 56 (1999);

Grayned v. City of Rockford, 408 U.S. 104, 108-09 (1972); Maine Milk Producers, Inc. v. Commissioner of Agriculture, Food and Rural Resources, 483 A.2d 1213, 1220-21 (Me. 1984); Maine Real Estate Commission v. Kelby, 360 A.2d 528, 531 (Me. 1976); Shapiro Brothers Shoe Co., Inc. v. Lewiston-Auburn Shoeworkers Protective Association, 320 A.2d 247, 253 (Me. 1973) (footnote omitted). As if to underscore the problem with the Board's position, Schramm testified that the Act provides no prescription for what initiatives should be included in AMCS and provides no specific time frames for measuring AMCS for the second assessment year. R-5048, 5049, 5094, and 5131. As a result, Mercer used various timelines with overlapping and contradictory time periods for different categories and initiatives in its determination of AMCS for the second year. R-5049, 5094, and 5131. Such a vague provision simply does not give the Board carte blanche to recognize various categories of putative savings as it desires and without legal foundation in the terms of the Act (especially when the Board is interpreting the Act in order to fund DHA's own operations and programs).

Either the Act defines what constitutes AMCS or it does not, and if it does not it is unconstitutionally vague. The uncontested record evidence supports the conclusion that, according to the terms of the Act and its legislative history, only Uninsured Initiatives should be included in AMCS for the second assessment year; there is absolutely no record evidence to reasonably support the Board's contrary conclusion. By disregarding the terms of the Act and instead choosing to interpret the Act as providing for a limitless AMCS, the Board adopted an interpretation that unavoidably and directly leads to the conclusion that the Act is unconstitutionally vague. In either event, there is no reasonable support in the record for the Board's conclusion that the Act permits categories other than Uninsured Initiatives to be included in AMCS for the second assessment year.

C. There is no reasonable support in the record for the Board's conclusion that savings other than BD/CC and MCAE were caused by Dirigo, and so only savings from BD/CC and MCAE should be included in AMCS for the second assessment year.

In order to avoid the limiting (or unconstitutionally vague) language of the Act, the Board captured within AMCS all of the savings they determined to be caused, in one way or another, by Dirigo. Again, however, the Act simply does not define AMCS as anything causally (no matter how gauzily) connected to Dirigo. Moreover, in doing so the Board implicitly adopted what Mercer described as its "critical hypothesis" – the notion that Dirigo generally was the primary driver of positive savings in all of the savings initiatives – even though the record contains absolutely no reasonable support for the "critical hypothesis." Indeed, Schramm testified that Mercer made no attempt to correlate any of the putative savings they identified with any provision of the Act; that is, he admitted that the record contains no support for the "critical hypothesis." R-5048, 5135, 5136, 5138.

As any child knows, merely saying something is so does not magically make it so, yet the Board's methodology for determining AMCS simply attempts to gather up all of the downward fluctuations in heath care costs that have occurred since the Act was passed and call them "savings related to Dirigo." But coincidence of timing is not sufficient evidence of causation; coincidence merely supports the logical fallacy known as *post hoc ergo propter hoc* – *e.g.*, the rooster crowed before the sun rose, therefore the rooster caused the sun to rise. The existence of putative savings after the Act was passed does not mean that the Act caused the putative savings.

Indeed, the record reflects extensive and uncontradicted testimony from several witnesses regarding the many various factors entirely unrelated to Dirigo which have influenced fluctuations in the costs of health care. See Rottkamp Prefiled at 5-8, (R-2987, 2992-95) (adopted at hearing by Jason Meade) (R-5030-31) and exhibit 1 at 13-16; Fishbein Prefiled at 5,

9 (R-2955, 2960, 2964); Fishbein Testimony (R-5189); Sheils Prefiled at 7-8; (R-3784, 3790-91); Sheils Testimony (R-5167); Mercier Prefiled at 8 (R-4320, 4327); Mercier Testimony (R-5158). See also Kenney Prefiled at 5-8 (R-4088, 4093-97); Kenney Testimony (R-5026-27); Bubar Prefiled at 6-11 (R-4100-05); Bubar Testimony (R-5027); Levesque Prefiled at 3-6 (R-4064); Levesque Testimony (R-5026); Roberts Testimony (R-5181).

In his Prefiled Testimony, John Sheils offers a litany of other possible factors which could affect health care costs in Maine: "changes in patient volume, changes in patient case mix and payor mix, opening or closing a hospital wing, overtime pay for nurses due to nursing shortages, changes in reimbursement levels from public payors, … overarching trends in the health system, … [and] employer health and wellness programs." R-3784, 3790. Moreover, the methodology adopted by the Board in its Decision fails to control for the national trend of decreasing health care costs, even though Maine certainly is not immune from the various factors affecting national trends which have nothing to do with any aspect of Dirigo. R-2965, 2992-93, 3001, and 3013.

The last item on Sheils' list is exemplary, and dramatically portrays the perversion built into the methodology adopted by the Board's Decision. Maine health plans and self-insureds increasingly have sponsored successful wellness or disease management programs – *e.g.*, Bath Iron Works' Building Healthy Ways program, Cianbro's Healthy LifeStyles Program, and Unum's Health Resource Center – which have produced savings in health care costs. R-3784, 3790-91, 4059-62, 4088, 4092-95, 4103-08. The undeniable bottom line for such programs is that healthier people need less health care. See Id. Under the Board's Decision, however, any cost reductions generated by such wellness efforts are counted as savings related to Dirigo and so are included in AMCS. R-2992-95, 3700-02, 3791. Perversely, then, the Board's Decision holds

that health plans and self-insureds should be charged (via the SOP based on AMCS) for enabling a healthier population. R-3791. And to doubly ensure that no good deed goes unpunished, the Board's Decision mean that those companies which offer health insurance to their employees will be forced to subsidize the health insurance for employees of companies, even possible competitors in the marketplace, which do not offer health insurance. See Id.

DHA freely admits this fatal flaw in its case. Mercer's Steven Schramm has admitted that DHA's calculation of AMCS did not even attempt to account for the variety of factors impacting health care costs, but instead simply counted "savings to the health care system in totality." R-5048, 5094, 515. According to the written summary of an August 2, 2005 meeting of the so-called "SOP Working Group," Schramm advised the group that Mercer chose an approach that did not separately identify savings associated with the Dirigo Health Act." R-3870, 3872. And in his testimony in the 2005 Hearing, Schramm admitted that it was "probably impossible to" segregate savings generated by Dirigo from savings potentially attributable to a host of other factors known to influence the data the consultants used. R-3039-40.

The evidence in the record clearly and unequivocally establishes that (1) health care costs fluctuate for reasons that have nothing to do with Dirigo, and (2) Mercer, DHA, and ultimately the Board could not, and did not even attempt to, separate putative savings at all related to Dirigo from putative savings unrelated to Dirigo. Moreover, there is no record evidence supporting the Board's fundamental proposition – the "critical hypothesis" – that all of the downward fluctuations in the costs of health care, *ipso facto*, are "savings related to Dirigo." Therefore, the Superintendent should conclude that there is no reasonable support in the record for the Board's conclusion that savings other than Uninsured Initiatives were related to Dirigo. Accordingly,

only putative savings from Uninsured Initiatives should be included in AMCS for the second assessment year.

III. The record does not reasonably support the Board's determination that AMCS amounts to $41,757,000.

For the reasons stated above, only Uninsured Initiatives should be included in AMCS for the second assessment year because there is no evidence in the record to support the Board's determination that other initiatives are either contemplated by the Act as part of AMCS or otherwise related to Dirigo. Even if the Superintendent somehow upholds the Board's decision to include various other initiatives, however, the Superintendent must then determine whether there is reasonable support in the record for the Board's calculations of savings within each of those initiatives. Upon such review, the Superintendent should conclude that the record does not reasonably support the Board's determination that AMCS amounts to $41,757,000.

Indeed, the record evidence makes clear that the Board's calculation of $41,757,000 in AMCS is predicated upon several omnibus fatal flaws as well as several fatal flaws specific to the calculation of savings for particular initiatives.

A. The Board's calculation of AMCS includes putative savings that have not been realized by payors.

The statement of "Guiding Principles" contained in the proposed methodology DHA presented to the Board holds that "when calculated, the savings will be used to sustain Dirigo Choice at no additional costs." R-1406-07 (emphasis added). This "Guiding Principle" is consistent with the language of the Act and the legislative intent behind it which require that AMCS must reflect only savings which have accrued directly to payors and, ultimately, to end purchasers in the system – consumers and employers. After all, the primal justification for having carriers pay an SOP was to "offset" *actual savings* for providers generated by Dirigo

Health's insurance program, which the providers would then pass along to carriers in the form of lower charges. Indeed, this is precisely how the Governor's Office of Health Policy and Finance described this critical provision in the Act in June 2003: "Payments will be made by insurers to Dirigo Health only after savings are shown. Insurers' payments will offset savings so payments will never exceed the savings." (R-2979). And during debate on the original Act, Representative Glynn testified as follows:

> Essentially the way the offset payments are going to be assessed is that when folks sign up for Dirigo it is anticipated that there is going to be a reduction in bad debt and charity care at doctor's offices and hospitals … Those savings are expected to be reflected in reductions and rates at hospitals and at doctor's offices. It is then expected that because the savings are reduced at doctor's offices and hospitals that that savings in turn is going to be passed onto the insurance carriers, which, in turn, will ultimately be passed on to the businesses and also passed onto the consumer.
>
> This was an area that was substantially negotiated and one that helped earn the support for the Majority Report that we are debating this evening. Why this is important is the tax that is going to be assessed, it is a tax, can only be assessed to a maximum of whatever the savings is actually going to be realized … The language in the bill is intended to set a maximum amount that this tax can ever be assessed at 4 percent. However, which is important, is the tax that will be assessed up to that maximum cap will never be greater than the bad debt and charity care that are actually going to be realized by both the hospitals and doctor's offices, that is then realized by the insurance carriers, which then will offset that tax. (emphasis added)

Legislative Record, House, June 12, 2003 (remarks of Rep. Glynn, S. Portland).

Moreover, §6913(9) of the Act requires that filings with the Superintendent in support of health insurance rates or rating formulas reflect, as part of the claims experience, "known changes in payments by the carrier to health care providers in this State, including any reduction for bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health" as well as any post-June 30, 2004 expansion in MaineCare

enrollment "as determined by the [B]oard consistent with subsection 1." 24-A M.R.S.A. §6913(9). "[K]nown changes and offsets in payments" is another term for "realized" savings, meaning that the only savings recognized in a rate filing case (for purposes of offsetting the amount of premium to be charged) would be "realized" savings related to "any reduction for bad debt and charity care … as a result of the operation of Dirigo Health."

Unfortunately, the Board cast aside this "Guiding Principle." Instead, the Board adopted the misguided notion that all putative reductions in the overall cost of health care which are "recoverable" by payors may be included in AMCS for the second assessment year. But the record evidence simply does not support the Board's determination that $41,757,000 (or even any lesser amount) for the second assessment year is "recoverable" by payors.

As a starting point, payors cannot "recover" 100% of putative savings in the health care system in the future given that approximately 50% of the Maine market is insured under MaineCare and Medicare. R-4336. Also, despite the obvious intent of the Legislature, the Board focused solely on the providers' costs, stopping well short of the Legislature's requirement that AMCS be based on reduced costs to payors. For example, merely showing that certain hospitals have reduced their cost per case mix adjusted discharge, or have voluntarily reduced their consolidated operating margins, does not establish that any payor's spending on health care has been reduced. R-4327-36.

Indeed, at least two of Maine's payors – Aetna and CIGNA – have not experienced any meaningful reduction in the overall growth of health care costs as a result of Dirigo Health or an expansion of MaineCare enrollment, or, for that matter, as a result of any of the other categories of putative savings contained in the Board's determination of AMCS. R-2964, 2993. Jason Meade, adopting the testimony of Jennifer Rottkamp of CIGNA, noted a slight easing of hospital

cost increases during the period under review in this case, but observed that if Maine hospitals have enjoyed cost savings "the hospitals do not appear to have passed more than a small portion of them on to us. In fact, the hospitals continue to advise our provider contracting staff that their savings resulting from reduced bad debt and charity care have been largely offset by expansions in MaineCare." R-2993. And Dr. Fishbein of Aetna noted that although Aetna has seen some temporary reductions in charges by two Maine hospitals, "Aetna has seen no net reductions in hospital charges either from these particular hospitals, or from Maine hospitals in general." R-2964.

Dr. Fishbein then expanded on the "offset" noted in the Prefiled Testimony of Ms. Rottkamp. Citing legislative testimony in February, 2006 in opposition to LD 1935 by Stephen Michaud, President of the Maine Hospital Association ("MHA"), and Elizabeth Mitchell, Director of Government and Employer Relations at MaineHealth, Dr. Fishbein related that MaineCare payments to hospitals were cut by nearly $34 million for the state's fiscal year ending June 30, 2005. R-2964. 2980-85. According to MHA and MaineHealth, as well as Dr. Fishbein, the reduction in MaineCare payments effectively wiped out any savings the hospitals might have seen as a result of the expansion of MaineCare enrollment (or, for that matter, the operation of Dirigo Health). R-2965, 2980-85. Additionally, the hospitals made up for the nearly $34 million cut in MaineCare payments by shifting costs onto private-sector payors. R-2963, 2980-85.

As noted above, the Act requires that any putative savings must be realized by payors before they can be counted in AMCS. But the Board failed to account for the multivalent disconnections between any putative savings in the health care system and realization of those putative savings by payors. Therefore, the Superintendent should find that the Board's determination of AMCS – which includes a great range of putative reductions in the overall cost

of health care, whether or not realized (or even realizable) by payors, within the ambit of AMCS – is completely unreasonable and contrary to the record evidence.

B. The Board's calculation of AMCS includes putative savings that are not "measurable" as the Act requires.

Any calculation of putative savings must include only amounts that are measurable; obviously, if something is not measurable, then it cannot be counted. Moreover, § 6913(1) of the Act explicitly provides that the "cost savings" must be "measurable." To be "measurable" (*i.e.* capable of being measured), data must be objective, verifiable, and attributable to a particular cause. But DHA's proposed methodology does not allow for a "measurable" determination of AMCS; instead, it contains putative savings in each of the four initiatives that are purely speculative, conjectural, and unattributable to any cause. As is made clear above, the methodology for calculating AMCS is thoroughly flawed, *inter alia*, because it includes putative savings that are unrelated to "the operation of Dirigo Health" or the increased MaineCare enrollment, and that have not been realized by payors. Without attention to these boundaries, an accurate determination of "measurable" AMCS pursuant to DHA's proposed methodology is impossible.

C. The Board's calculation of AMCS for the second assessment year includes putative savings that have already been counted once before in AMCS for the first assessment year.

In an outrageous display of double-dipping, the Board's determination of AMCS for the *second* assessment year includes putative savings which were already counted as AMCS for the *first* assessment year. R-4984, 5047. The Board's Decision makes no mention of this fact, but it is important and should be reviewed by the Superintendent.

The Board's double-dipping renders the AMCS for the second assessment year entirely unreasonable because it is fundamentally contrary to the statutory purpose of AMCS as a limit on

the annual "savings offset payment" ("SOP"). Such double-dipping also is contrary to the position of the Governor's Office of Health Policy and Finance which stated in 2003 that "[p]ayments will be made by insurers to Dirigo Health only after savings are shown. Insurers' payments will offset savings so payments will never exceed the savings." (emphasis added) R-2979. Similarly, the Board's double-dipping is contrary to the "Guiding Principles" contained in the proposed methodology DHA presented to the Board. The Guiding Principles include the following:

- "Initiatives are primarily voluntary. It is the role of the marketplace to voluntarily comply with savings targets and to recapture savings in price negotiations." (emphasis added)
- "The savings, once calculated, should not be overstated, nor should they be understated: the methodology must be reasonable and appropriately measure the impact of Dirigo on the rate of growth in the health care system."
- "When calculated, the savings will be used to sustain Dirigo Choice at no additional costs." (emphasis added)

R-1258, 1406-07.

The SOP, after all, is designed to "offset" savings realized annually by the payors, and AMCS functions as a limit on the SOP that can be charged against payors each year. But if AMCS for year 2 includes savings that were already captured in year 1, then its purpose as a limit on the annual SOP for any particular year becomes entirely meaningless. Similarly, the Board's approach puts the payors in the impossible position of having to recapture savings from last year's marketplace which the Board assumes the payor already recaptured last year. This approach flatly denies the laws of logic and economics. And if allowed to grow unchecked, the Board's double-dipping in the second assessment year will only grow to triple-dipping in the fast-approaching third assessment year, thereby exponentially increasing the divergence between savings that may exist on an annual basis (and be offset by the SOP) and the AMCS counted repeatedly over multiple years.

As a result of this fundamental flaw in the Board's approach to calculating AMCS for the second assessment year, the Superintendent should conclude that the Board's calculation is unreasonable and not supported by record evidence.

D. The Board's determination of AMCS specifically for Hospital Initiatives (CMAD) is not reasonably supported by record evidence.

The Board reduced Mercer's recommended savings calculation on this issue from $72.7 million to $14.5 million by rejecting Mercer's projected growth rate absent Dirigo, which was based on the three years SFY 2000-2003, and which included the "anomaly" of a 10.1% increase in CMAD for 2002. The Board instead adopted a median projected growth rate of 4.7% as proposed by John Sheils, and depicted in Chamber Exhibit # 21, Table 7. R-4693. For the following reasons, this calculation is still not reasonably supported in the record.

Mercer's CMAD methodology for the second assessment year ("Year 2") is not related to Dirigo, nor is there any provision in the Dirigo Act that even requests that Maine hospitals limit their costs per CMAD for Year 2. Mercer and DHA based the tenuous relationship between Dirigo Health and the CMAD savings initiative for Year 2 not on the Act, but rather on a press release from the Maine Hospital Association ("MHA") to its members that had nothing to do with Dirigo. R-4310. Mr. Michaud emphatically confirmed this point under cross examination: "In the second [Dirigo] year, the Maine Hospital Association, not Dirigo, not the State of Maine, nobody else, established a voluntary cap for hospital expenses." R-5148.

This calculation and the resultant number it produces is not related to the operation of Dirigo Health, nor indeed even the Dirigo Health Legislation or Hospital Study Commission. Note also that the DHA was advised by counsel that it might "lose the [court] appeal on year 1 since [the CMAD restraints] were voluntary and not due to Dirigo." R-3026.

Moreover, even assuming, in the absence of record evidence, all of the MHA's members agreed to comply with the representations in the press release, and assuming some connection to Dirigo Health, there is absolutely no connection between Mercer's methodology for calculating CMAD and a 4.5% limit on cost increases per CMAD. Nowhere does the calculation actually compare anything to 4.5%. For this reason alone, the methodology and savings calculation for CMAD in Year 2 should be rejected by the Superintendent. However, there are numerous additional reasons to reject the Board's CMAD calculation.

First, as noted above, the calculation double-counts savings from Year 1 by including savings from 2003. This method should be rejected for the reasons set forth above, and also because the 4.5% voluntary limits are actually based on a single hospital fiscal year rather than multiple hospital fiscal years or multiple Dirigo years. This is further evidence that the savings are to be measured over a one year period.

Second, Mr. Schramm testified that Mercer:

- Proposed a Year 2 CMAD methodology that does not parse which savings are related to Dirigo Health and which are not. R-5115.
- Did not analyze whether hospitals could use alleged cost savings to reduce charges to payers. R-5118.
- Did not take into account the $58 million in Medicaid (MaineCare) cuts in SFY 2003 and 2004. R-5118. See R-2958-63; R-2980-85.
- Did not take into account the hospital provider tax imposed by the State of Maine. R-5118. See Michaud testimony (confirming $58 million in MaineCare cuts and no other increases in relevant period other than to partially fund hospital provider tax). R-5145.
- Did not take into account the $200 million owed by the Maine Department of Human Services to Maine hospitals due to volume increases in MaineCare utilization in excess of that accounted for in prospective payments to hospitals, and the limiting effect on hospitals' ability to pass alleged CMAD "savings" on to payers. See Michaud testimony. R-5146.

- Did not take into account the fact that the proposed $72.7 million CMAD savings, together with the proposed savings on the other three categories (for a total of $91 million) would exceed the total operating income of all of the thirty six (36) measured hospitals in Maine. R-5119.

- Did not contact any of the hospitals nor conduct any written surveys to verify if volume or some factor other than Dirigo was the cause of a decrease in cost per CMAD. R-5119.

- Did not verify whether its CMAD methodology produced savings in other states where Dirigo does not exist, nor for time periods prior to the enactment of the Act. R-5119.

- Did not control for the impact of volume on the calculation. R-5134.

- Did not take into account that fifty percent (50%) of hospital patients are covered by public payers such as Medicare and MaineCare, and that another ten per cent (10%) are uninsured. Michaud testimony. R-5147.

Third, Mr. Schramm confirmed many of the same points from last year's proceeding before the Superintendent which demonstrate that the CMAD methodology is not reasonably supported in the record:[6]

- Without any support or proof, he claimed that Dirigo was the 'primary driver" of positive savings in the Maine healthcare system. R-5135. Several witnesses again this year directly refuted this point, including Sharon Roberts of Anthem. R-5181. Dr. Fishbein of Aetna testified: "There are certainly many other cost drivers driving the cost of healthcare in Maine. Maine is not immune from national trends and other factors, and you've heard many people today talk to what some of those are: prescription drugs, Medicare reform, change in volumes at hospitals, cost shifting. There are numerous other factors that are at least as significant, if not moreso, than the Dirigo impact." R-5189.

- Three employer witnesses for the Chamber, Linda Levesque from UNUM, Maureen Kenney of Bath Iron Works and Rita Bubar of Cianbro also emphatically disagreed that Dirigo was the primary driver of reductions in CMAD. Levesque prefiled R-4064; hearing testimony R-5026; Kenney prefiled R-4093-97; hearing testimony R-5026-27; Bubar prefiled R-4105-06; hearing testimony R-5027.

- Mercer made no attempt to attribute to Dirigo any particular savings including CMAD, rather than to some other, non-Dirigo factor such as volume. R-5135.

[6] See generally MEAHP Exhibit 7; R-3027-3051 (Schramm testimony in INS-05-700); MEAHP Exhibits 12 – 16 (Responses to Data Requests in INS-05-700); R-3072-3084).

- Mercer did not attempt to control for the effects of normal fluctuations in volume, nor for the finding of "savings" in other states where Dirigo does not exist. R-5135.

- Mercer did no statistical validation. R-5136.

- Mercer did not control for external factors that could influence CMAD the calculation, R-5138.

- Mercer did not determine whether hospitals in fact achieved the voluntary cost restraints, and why they might have done so. R-5139.

- Mercer did not attempt to verify if the "savings" were passed on to the payers. R-5139.

Fourth, Mr. Schramm's characterization of the CMAD methodology as being conservative was simply not true. In the first assessment year ("Year 1"), using a similar "conservative" methodology, the Superintendent reduced the proposed CMAD savings calculation from $75 million to $33.7 million. This year, applying the Year 2 methodology to the Year 1 data would result in a CMAD savings of $76.5 million. R-5123. Mr. Schramm, who admitted he was not an actuary, does not have a Ph.D. in Public Health, does not have an M.B.A. degree, and has no expertise in hospital finance, led the Mercer team on the CMAD issue. R-5132. He relied on Dr. Nancy Kane for this expertise even though Kane did not participate in the creation of Mercer's Year 2 methodology and did not testify in the hearing before the Board. R-5132.

Fifth, John Sheils, an expert in analyzing the cost impacts of programs designed to expand coverage, made several points which demonstrate that the Mercer CMAD methodology and calculation, even as reduced by the Board, is not reasonably supported:

- Healthcare is one-seventh (1/7th) of the United States economy and probably the most complex sector of the economy in terms of how we pay for it. "It is oversimplifying to say that the growth in spending that occurs in a given year can be attributed to any one thing." Sheils testimony. R-5167.

- A $50 million rate cut by Medicaid to hospitals can have a terrific impact on how a hospital manages itself; "I know that in other studies of cost growth, hospitals have taken into account things like that, the payment policies and managed care penetration, level of income in the state, economic activity, poverty levels, number of uninsured. It's a very complex business, and we're really not going to get a good, satisfactory solid estimate of what Dirigo or the MHA initiative had on hospital cost growth unless we can take a shot at sorting that out." Sheils testimony. R-5167.

- Using four years' baseline data versus three as used by Mercer would result in negative savings in Year 2 of $14 million, which is very disconcerting, in that it shows the need for a longer baseline to control for random fluctuations. Sheils testimony. R-5169.

- Even using four instead of three years' baseline data, one cannot control for what savings are related to Dirigo versus other factors. Sheils testimony. R-5169.

- Moving the calculation back one year with a baseline from 1999 through 2002, and measuring for CMAD savings for SFY 2003 (the year before the Dirigo Act was enacted) results in savings of about $14 million. This statistical validation absolutely shows that something other than Dirigo is contributing to the substantial fluctuation in CMAD in Maine. Sheils testimony. R-5170. See generally Chamber Exhibit # 21 (Sheils Powerpoint). R-4686-96.

- There should be no savings in Year 2 when costs in fact grew by nearly 6.9%. Sheils Testimony. R-5172.

Sixth, Roland Mercier, who has over twenty five (25) years of experience with Medicare and Medicaid cost reports and hospital reimbursement in the State of Maine, provided testimony that demonstrates that the CMAD methodology and corresponding calculation, even as revised downward by the Board, is not reasonably supported:

- In response to a question from DHA Board Chairman, Dr. McAfee, the $33.7 million savings found to be reasonably supported last year by the Superintendent was not in fact reasonably supported. Mercier Testimony. R-5159

- CMAD is not the correct way to measure savings under the Dirigo initiatives; and the suggestions made last year by the Superintendent to correct the CMAD methodology is not any more appropriate, because the methodology "is still volume sensitive…even a small 3-6% [change in volume] has an $80 million impact on the savings." Mercier testimony. R-5159-60.

- Errors in Mercer's calculation of volume figures substantially threw off the CMAD savings calculation for Year 2. Mercier Testimony. R-5155. Specifically, Mr.

Mercier "ran another model using [Mercer's] exact CMAD amounts, except adjusting the denominator back to the volume statistics that were used to arrive at the $33 million last year." This was done to "test the impact of volume on the savings calculation." "There was an $80 million difference between the volume that Dr. Kane used last year and the volume that the Mercer report contained for Year 2." "There is no longer a savings [for Year 2] based on Dr. Kane's volume amounts in the first Dirigo year." Mercier Testimony. R-5155.

- A roughly 3% variance in total statewide volume between Year 1 and Year 2 had an impact of $80 million in the savings calculation. The Mercer methodology for Year 2 did not properly account for these volume issues. Mercier Testimony. R-5155.

- A volume swing of 3-4% from one year to the next is not unusual. Mercier Testimony. R-5155.

- Using Year 2 data with the year methodology as revised by the Superintendent results in no savings. Specifically, "comparing the historical trends that took place between 2000 and 2003 which resulted in a 1.9% historical growth over inflation is less than the actual experience that took place between 2004 and 2005. So there is no savings." Mercier Testimony. R-5156.

- The 6.85% actual cost growth from 2004 to 2005 in Year 2 is more than the historical growth rate above inflation (6%). Mercier Testimony. R-5164.

- In his opinion, the Dirigo reforms did not account as the primary driver for CMAD savings last year, and would "echo those same sentiments again this year…There are lots of variables that impact volume in the CMAD statistics." Mercier Testimony. R-5158.

Seventh, many of the same points were confirmed by the Anthem witness panel of Tom Drottar, Bill Whitmore, Jack Keane and Sharon Roberts:

- According to hospital contracting specialist Tom Drottar, sixty percent (60%) of hospital utilization on average is from non-private payers and it is not reasonable to include discharge and cost data for these non-private payer patients in calculating savings under the CMAD methodology. These discharges are irrelevant to the negotiation of contracts between hospitals and private payers and savings should be adjusted to reflect private payer only discharges at 40%. Drottar Testimony. R-5174.

- Mr. Whitmore, an actuary, agreed that if one "reduces discharges by the 60% relating to non-private payers, then the calculation of savings should be reduced by a directly proportional amount." Whitmore Testimony. R-5174.

- Per Anthem Exhibit # 8, R-3466, the actual cost growth from state fiscal year 2004 to 2005 was 6.85%, using the numbers from Appendix D to the Mercer May 2, 2006

Supplemental Report. R-1453. Using an expected growth rate of the HMBI statistic from 2004 to 2005, coupled with the growth rate above inflation and the baseline period of 1.93%, for a combination of 6.24%. A "comparison of the two calculations suggests that the actual cost increases from 2004 to 2005 were greater than the expected increases during that same period." Whitmore Testimony. R-5175.

- "It is not reasonable for the CMAD methodology to have calculated $33.7 million for state fiscal year 2004 when the cost growth was 1.93% but almost $70 million in state fiscal year 2005 when the [actual] cost growth was nearly triple that figure. The actual rate of growth has accelerated beyond what the expected rate of growth which is included in the model." Whitmore Testimony. R-5175.

- Even using the aggregate CMAD measurement of cost results in "this tremendous amount of variation [based on fluctuation in volume]." "You'd be very hard-pressed to find a commodity or a service anywhere in the economy that's shown the kind of volatility in unit cost over the last three or four years." Keane Testimony. R-5176.

- Applying the Mercer year 2 methodology to year 1 data would produce "savings' of $76.5 million. This is not a conservative methodology. Whitmore Testimony. R-5177.

- The reason that Mercer can show savings in Year 2 "is simply that they include in their projection the year that basically I would think spawned the Dirigo legislation. It's the year when hospital costs went up 10.12%. That's obviously a horrendous experience, and they're incorporating that as one-third of the base of their trend projection…. I think to project out as a basis for savings using a year in which the experience was so horrendous that it actually spawned the legislation, is going to give you false savings for a considerable period into the future." Keane Testimony. R-5179.

E. The Board's determination of AMCS specifically for Uninsured Initiatives (BD/CC, MCAE, and WW) is not reasonably supported by record evidence.

MEAHP does not dispute that savings from a reduction or avoidance of bad debt and charity care and from increased enrollment in MaineCare as a result of an expansion in MaineCare eligibility for adults are to be included in AMCS. In each of the sub-parts of this initiative discussed below, however, the amount of savings is not reasonably supported by record evidence which indicates that the figure has been overstated by erroneous assumptions (which are certainly not "conservative" as characterized by the Board) and by double-counting;

therefore, the amount of savings for Uninsured Initiatives should be reduced significantly by the Superintendent.

1. Bad Debt and Charity Care

Kevin Russell, a member of the Mercer team, was the only witness to testify on the Uninsured Initiatives and he was the lead for Mercer on these issues. Under cross-examination he made the following admissions:

a. Uninsured

- He agreed that the Dirigo Act does not specify how bad debt and charity care savings are to be calculated, and admitted that Mercer did not factor in any adjustment as to whether those savings would be realized 100% or less by the payers. R-5002.

- He relied on Nancy Kane's report entitled "Bad Debt and Free Care Baseline Analysis and Recommendations for Purposes of Determining Savings Offset Payment. R-4981. See R-3637-50 (text of report).

- He adopted her assumption that acute care hospitals represented roughly 84% of aggregate uncompensated care in 2002 and 2003, but did not adopt her assumption that for 2003 46% of hospital bad debt charity care was attributable to the uninsured. Instead, Mr. Russell used 50% as the assumed percentage. Russell Testimony. R-4981.

- Mr. Russell had no other documentation or independent analysis to support the use of the 50% assumption. R-4981.

- When asked if this change would result in $100,00 less in savings, he stated that he had not done the calculation, but agreed that using the 46% versus 50% assumption in the calculation in Appendix E (R-1454), a corrected number would be produced. R-4981.

- He used a 9.2% HMBI inflation factor to trend forward the bad debt and charity care assumption to 2006, a 27-month period. R-4982.

- He did not account for the $10 million drop in bad debt and charity care from 2002 to 2003, as confirmed in the Kane report at R-3643, and provided no documentation or independent analysis to support his more aggressive assumption in the growth of bad debt and charity care in the trend used to bring the figure up to 2006, (which increased the amount of savings). R-4982.

- He produced no independent analysis or documentation on the (in some cases significant) amounts of deductibles and co-pays that Dirigo Choice enrollees must pay, and the impact of these requirements in reducing the overall savings under this initiative. R-4982.

- He used an assumed level of 61% of those joining Dirigo Choice being previously insured, even though the Muskie School Study (R-3667) stated that in fact 72% were previously insured. R-4983.

- Even though Mercer was measuring the uninsured savings amounts for those who enrolled in Dirigo Choice in 2005, he used the 2006 figure (61%) which was more aggressive, resulting in a larger savings amount than if Mercer had used the actual data for 2005 (which showed a much smaller population of previously uninsured). R-4983.

- He admitted that in last year's proceeding before the Superintendent he reported that 8,000 people were covered under Dirigo Choice. Not all of the 8,665 people reported this year as enrolled in Dirigo Choice are newly insured in the program. In fact of these people 8,000 were insured in calendar year 2005. R-4984. This constitutes double-counting and should be adjusted by the Superintendent.

- Some of the savings in this sub-category, as well as for all three other sub-categories, have not yet occurred, as they were projected to the end of calendar year 2006. R-4991.

- He did not verify Mercer's bad debt and charity care assumptions and corresponding savings estimates for 2005 by using actual data from Medicare cost reports. R-4991.

- He admitted that a reduction in bad debt and charity care does not always result in hospitals passing on that reduction in the form of lower charges to private payers. R-4994.

b. Underinsured

- Mercer used the following definition of "underinsured:" Persons with income levels at or above 300% of the federal poverty level. R-3651.

- Mercer did not independently verify the actual number of new Dirigo Choice enrollees that met this definition; rather Mercer assumed that 20% of bad debt was due to the underinsured. R-4987.

- Mercer did no analysis of the breakdown between underinsured and those that just don't pay their bills, nor of the percentage of bad debt and charity care that is for people over the 300% of the federal poverty level. R-4988.

- Instead Mercer merely assumed, without conducting any independent analysis or documentation, that 25% of those not uninsured when coming to Dirigo Choice were underinsured. R-4988; 4989.

- Mercer did not make any calculations regarding the deductible levels the previously underinsured had in comparison with the deductible they had after joining Dirigo Choice. R-4988. See R-3671 (Muskie School Study showing various deductible levels for previously underinsured prior to joining Dirigo Choice).

2. MaineCare Expansion

- Mercer did no analysis of whether these new MaineCare enrollees had insurance prior to enrolling even though these new enrollees could be eligible for MaineCare up to 200% of the federal poverty level. R-4990.

- Mercer did not analyze the impact of this type of MaineCare expansion tending to "crowd out" those previously insured. R-4990.

- Mercer made no adjustment for the "crowd-out" factor, even though it had available to it documentation of the prior insurance deductible levels by income levels, including those up to 200% of the federal poverty level. R- 4990. See R-3671 (Muskie School study containing referenced information).

- Mercer had produced a spreadsheet to prepare this year's calculations, on which a note appears: "inverse relationship between public and private expansion." R-3721.

- Mr. Russell agreed that "crowd out" reduces private coverage with replacement by public coverage, but did not make an adjustment for that effect. R-4991.

John Sheils offered several pertinent observations about these initiatives that should be considered by the Superintendent in reducing the savings calculation;

- Mercer's failure to adjust for the "crowd out" of those previously insured with private coverage with new public MaineCare coverage is an important mistake, as 40% of those people at 200% of the federal poverty level have private insurance. R-5015.

- For the overall uninsured and underinsured methodology, Mercer did not use actual bad debt and charity care experience for hospitals in 2005 to 2006, and that it was very important to reconcile Mercer's estimates with what actually occurred. R-5015.

- Mercer did not account for the $10 million drop in bad debt and charity care in 2003 in adjusting their assumptions about the baseline amount of these costs. R-5015.

- Mercer accounted for 50% of the bad debt and charity care as uninsured, 20% underinsured and 22% those under public coverage, but inappropriately failed to account for the remaining 8% of total bad debt and charity care. R-5015-16.

- The Medicare population, for example, has "some very substantial out-of-pocket expenses from a hospital," and that is why "we get some fairly good sized uncompensated care in that population." R-5016. For this reason the calculation should be adjusted to account for the missing 8% of bad debt and charity care.

3. Woodwork Effect

In this sub-category, Mercer proposed savings based in part on actual enrollment numbers in MaineCare of those who applied for DirigoChoice coverage but were found to be eligible for MaineCare. Mercer projected such enrollment figures through December 2006 with actual data only through April 2005. Although the savings figure for this sub-category is very low, there is no reasonable support for this part of the calculation because entirely and utterly speculative.

F. The Board's determination of AMCS specifically for the Certificate of Need and Capital Investment Fund Initiatives (CON/CIF) is not reasonably supported by record evidence.

The only witnesses that testified for DHA on this issue were Steven Schramm and Cathy Cobb, an employee of the Maine Department of Health and Human Services. A review of their testimony and related exhibits demonstrates that there is no reasonable support for a finding of any savings on this initiative. Mr. Schramm specifically made the following admissions:

- He was not familiar with how the CON statute operated in Maine prior to the enactment of the Dirigo Act. R-5045. He is not an expert on Maine's CON statute and relied on Ms. Cobb to provide expertise on the CON process in Maine. R-5047.

- None of the CON applications in question had been approved or denied by the date of the hearing, and none of the hospitals had incurred substantial costs that are associated with the CON applications for which Mercer found savings. R-5045.

- None of the hospitals will incur substantial costs until the time the application is approved and they undertake construction and renovations. R-5045.

- He had no evidence that hospitals will increase their charges in anticipation of a project being approved. R-5045.

- If a project were denied for a reason that was in the CON statute prior to the creation of the Dirigo legislation, it would not constitute savings. R-5045.

- Mercer produced no documentation that any hospital withdrew its application because of any new CON requirement that was part of the Dirigo legislation. R-5046.

- The $400,000 review threshold was in the CON statute prior to the Dirigo Act. R-5046.

- Any alleged savings will not be incurred in 2006 but sometime in the future, which for substantial projects would be at least three years into the future. R-5047.

- When costs, if any, associated with these projects are incurred, they will show up on the hospitals' Medicare cost reports and would be double-counted in the CMAD calculation a few years from now. R-5047.

- The Dirigo Act does not provide a time frame within which to measure savings for this initiative, and Mercer came up with two different methodologies for year 2 on this initiative, with different proposed timeframes, as shown on a timeline Mercer prepared. R-5049; R-3021 (MEAHP Exhibit # 3 - timeline).

- Mercer in fact developed multiple iterations of the timeline showing different possible timelines. R-5050.

Ms. Cobb, Director of the Division of Licensing and Regulatory Services for the Maine DHHS, also made several admissions that show that the Superintendent should completely reject any savings under this category as not being reasonably supported. First, as to projects Mercer claims were withdrawn due to "new" CON requirements adopted as part of the Dirigo Act:

- Both methodologies developed by Mercer in Year 2 differ from that presented in Year 1, for a total of three different methodologies on this initiative. R-5040.

- The Dirigo Act does not specify a methodology for calculating savings under this intiative. R-5040.

- Eastern Maine Medical Center withdrew its application because it could get the third year operating costs below $400,000 CON review threshold. R-5033.

- The $400,000 review threshold pre-dated the Dirigo Act and was not created in the Dirigo Act. R-5033.

- The withdrawn Inland Hospital 150-bed replacement hospital CON application would have to compete with a proposal from MaineGeneral Medical Center under criteria in the CON statute that pre-date the Dirigo Act, and which could be grounds for Inland to have withdrawn the application. These criteria include the need for more than one 150-bed replacement hospital and the feasibility and financial sustainability of the project. R-5034.

- Ms. Cobb produced no documentation from Maine Medical Center that it withdrew its CON application for Lobby Improvements due to any new requirements in the CON statute that were enacted as part of the Dirigo Act. R-5043. The same is true for the other three withdrawn CON applications listed on the first page of Appendix G. R-5040.

Second, as to projects Mercer claims will not be approved in the future based on the Capital investment Fund limits:

- DHA has not yet made a final or even preliminary decision on which of the projects listed on Appendix G will be approved or denied. R-1462.

- Each project must go through the CON review process, which includes looking at whether there is a need for the project, which is a requirement in the CON statute that pre-dates the Dirigo Act. R-5035.

- None of the projects have incurred any but minor costs to date, and all, given their large size and scope, will take several years to build. R-5037.

In short, Mercer made completely unreasonable and speculative assumptions that: (1) if a project application was withdrawn it was due to "new" requirements enacted in the Act, when in fact those requirements pre-dated the Act (R-1460) and without any documentation to support the reason the application was in fact withdrawn; (2) but for the Capital Investment Fund limit all but two large projects would be denied (R-1461-62), without accounting for the fact that all four could be denied or significantly modified for other reasons on the merits within the CON statute (see 22 M.R.S.A. § 335(7)), as opposed to CIF considerations; and (3) the speculative amount of savings or avoided costs several years in the future can be reduced to a present value in today's dollars. With respect to Mr. Schramm's testimony acknowledging and confirming that the CON

savings calculation captures future savings, this violates a fundamental principle of savings – that the savings be actually realized. R-2979. Moreover, counting future realized savings in the current year (Year 2) does not reasonably permit the market to recapture savings through price negotiations. Thus, as explained above, Mercer's Guiding Principles are not met and private payers must pay a tax to fund Dirigo Health and a MaineCare expansion. For the Board to conclude that it found Mercer's approach "very conservative" is astounding. This is simply another case of over-reaching by Mercer and DHA and no savings should be allowed on this initiative as being reasonably supported by the Superintendent.

G. The Board's determination of AMCS specifically for the Health Care Provider Fee Initiatives (PIP and FPP) is not reasonably supported by record evidence.

Mr. Schramm, Rebecca Wycke and Geoffrey Green testified in support of these hospital and physician initiatives on behalf of DHA. Although the Superintendent allowed some savings on this initiative for Year 1, the record for Year 2 does not this year reasonably support a finding of any savings. In fact, both parts of this methodology do not even make sense, are illogical, fundamentally unfair and should be rejected.

- Mr. Schramm testified that Mercer thought it was appropriate to include this initiative for Year 2 because the Superintendent last year adopted the inclusion of the hospital and physician initiatives. R-5092. Not only is this circular logic, but it is fundamentally flawed, as the Superintendent specifically did not review the Board's legal interpretation of the Act last year to verify which initiatives should or could be included in the AMCS calculations. Without any independent analysis, Mercer assumed that it is proper to include this initiative.

- Mr. Schramm admitted that this methodology does not make the connection between the reimbursement and actual savings within the system, and thereby did not adjust at all or take into account what ultimately gets negotiated between payers and the providers. R-5093.

- He also agreed that the only way to get an actual reduction in cost shifting is if there is an actual reduction in the charges that providers charge to third-party payers. R-5094.

- He also admitted that the Dirigo Act does not specify a timeline for measuring savings under these initiatives. R-5095; R-3021 (MEAHP Exhibit # 3 - timeline), and that Mercer prepared probably "a half dozen" of these draft timelines. R-5095.

- He did not account for the fact that physicians in Maine have been waiting for years for an increase in Maine Care payments. R-5095.

- He did not account for the fact that there have been regulatory restrictions on access that have a limiting effect on the ability of payers to negotiate lower rates with the providers. R-5095.

- He did not account for the fact that there are studies as Mr. Sheils testified last year that physicians generally pass only 20 to 40% of payment increase from public payers like MaineCare on to private payers. R-5095.

When cross-examined concerning the Provider Fee Initiative, DHA witness Mr. Geoffrey Greene admitted that hospital PIP payments and future payments to physicians are not administered by Dirigo Health. R-5052. Indeed, federal Medicaid law requires Medicaid to be administered by a single designated state agency, and the State of Maine designated DHHS. R-5052. Therefore, even assuming any savings, they cannot be as a result of Dirigo Health. Moreover, there is nothing in the record to support the blind assumption that increases in payments that hospitals have already booked as receivables actually result in savings. The gist of Mr. Greene's testimony was that he heard that some hospitals may have some costs associated with low PIP payments and late MaineCare settlements. R-5055. It is unreasonable and illogical that the State may create costs (assuming costs are actually created) through low and untimely MaineCare payments on one hand, but on the other hand do what is right to correct the situation with reasonable PIP projections, and then use the projected future payments as a basis for an SOP assessment that hospitals will have to pay as insurers of its employees, along with other self-insured employers and insurance plans. Putting aside this observation, there is no competent evidence that this initiative actually reduces a hospital's costs. Therefore, the methodology for determining putative savings related to PIP increases does not reasonably permit the market to

recapture savings through price negotiations, yet it assumes, as admitted by Mr. Green, that every dollar of savings calculated to hospitals and physicians will, dollar for dollar, be counted as savings. R-5056. These alleged savings should be rejected by the Superintendent as not reasonably supported.

Regarding future payments to physicians, the basis for the increase, as reflected in the Hospital Commission Report, was a long-overdue increase to address MaineCare access problems with physician services. To meet the Mercer Guiding Principles, Dirigo Health would have the Board believe that the physicians must turn over this admittedly long-overdue increase in payment rates directly to insurers during the course of price negotiations. Indeed, Sharon Roberts from Anthem testified that Anthem pays most physicians in Maine based on a standardized fee schedule for the vast majority of physician services. R-5098. She also testified that an increase in MaineCare reimbursement to physicians would have no direct impact on Anthem's reimbursement rates since such increased reimbursement would not change the reimbursement rates on the standardized fee schedule. R-5098. Even if a physician did lower her charges to Anthem based on increased MaineCare reimbursement, this would not result in Anthem's reimbursement unless the reduction was below the standard fee schedule rate. R-5098.

Finally, the following testimony by Ms. Roberts shows the utter fallacy of the rationale underlying the physician payment initiative. She testified that if the entire amount of the physician MaineCare fee increase is included in AMCS and later included in the savings offset payment, the result would be that the physicians would have to give back the entire increase to the private payers, which in turn they would have to pay to the DHA in the form of the SOP. This is not reasonable.

CONCLUSION

For all of the reasons set forth above, the Superintendent should:

1. reject the Board's determination of AMCS for the second assessment year in its entirety because it is predicated upon unacceptable violations of due process;

2. reject all of the savings initiatives contained in the Board's determination of AMCS for the second assessment year except for the Uninsured Initiatives because only the inclusion of Uninsured Initiatives in AMCS is reasonably supported by evidence in the record; and/or

3. reject the Board's determination of $47,757,000 because it is not reasonably supported by evidence in the record and issue its own determination of AMCS that is reasonably supported by evidence in the record.

Dated: June 23, 2006

/s/George M. Linge

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